**The Woodlands Lung Center**
**Dr. Eduardo E. Chang and Dr. Carlos E. Araujo Preza**
**3115 College Park Dr., Suite 110**
**The Woodlands, TX 77384**

**Patient Information**: (Please use full legal name)

Last Name:_________________________ First Name:_____________________ Middle Initial: ___

Address:_________________________________________________________________________

(Street) (Apt.) (City) (State) (Zip)

Home Phone___________________________ Cell Phone__________________________________

Date of Birth: ______________________ Age:_____ Sex: M F Social Security:________________

Email:_______________________________

Primary Care Physician:_________________________________ Phone Number:_________________

Race (Circle One): African American Hispanic Caucasian Other:________________________

Marital status (Circle One): Single Married Widowed Divorced

**Insurance Information: (Please provide original card for copies)**
**FOR OFFICE USE ONLY:**

**Primary Insurance:______________________________ID:______________________ Group:____________**
**Insurance Address:**
**____________________________________________________________________________**

**Policy Holder: ______________________________________ DOB________________**
**Relationship: ________**
**Effective Date: ______________________________ Phone Number: ______________________________**

**Secondary Insurance:_____________________________**
**ID:______________________Group:____________**
**Insurance Address:**
**____________________________________________________________________________**

**Policy Holder: ______________________________________ DOB________________**
**Relationship: ________**
**Effective Date: ______________________________ Phone Number: ______________________________**

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## Emergency Contact:

Name: ______________________________________________ Relationship: ___________________________

Primary Phone: __________________________________ Secondary Phone:___________________________

Signature: ________________________________________________ Date: ____________________________

## Consent to obtain Medication History: (Pharmacy Information)

Because we can connect with your pharmacy electronically, we may be able to upload your medication history, which will allow us to provide appropriate treatment and avoid potentially dangerous drug interactions; we may also use this service to facilitate the filling of your prescriptions.

I, __________________________________________ give permission to Dr. _________________________ or associates to access my pharmacy history through the Electronic Medical Record.

Pharmacy Name: _____________________________________ Phone Number: ________________________

Address: ________________________________________________________________________________

(Street) (City) (State) (Zip)

Patient Signature: ____________________________________________ Date: __________________________

## No Show Policy/Cancellation Policy:

Effective November 1, 2011, if you miss your appointment or cancel with less than 24 hours notice, Eduardo E. Chang M.D. P.A. and Houston Intensive Care and Pulmonary Associates reserve the right to bill you $25.00 for each no-show and late cancellation. This fee will be your responsibility and will not be billed to your insurance company. We do realize that on rare occasions, emergencies may arise and we will address these situations at that time. Additionally, we reserve the right to terminate our relationship with you after five (5) occurrences.

Patient Signature: __________________________________________________ Date ____________________

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## Consent to Treat:

I hereby consent to an evaluation, testing and treatment as directed by Eduardo E. Chang M.D. P. A. or associates or by Houston Intensive Care and Pulmonary Associates.

I have reviewed and confirmed that the information provided is correct.

Print Patient Name: ___________________________ Signature: ______________________
Date: __________

## Lifestyle History:

Have you ever been pregnant? Y N If yes, how many pregnancies? ___________________
How many live births? ___________________________

Have you ever smoked? Y N If yes, how many packs a day? ____________________
If yes, for how long? _____________________________

Do you currently smoke? Y N

Do you drink alcohol? Y N If yes, how often? _______________________________
If yes, what do you drink?

Do you exercise? Y N If yes, what activity, how often and how long?
_________________________________________________

Any use of recreational drugs? Y N If yes, when, how often and what drugs?
_________________________________________________

Any exposure to hazardous waste Y N If yes, what substance and when? ________________

or chemicals?

________________________________________________

Have you recently traveled outside Y N If yes, where, when and for how long? ____________
of the US?

________________________________________________

What is your current work status? Employed _______ Retired _______ Disabled _______
If you are currently employed: Where: _________________________ How long? ________________
Phone Number: _________________ Position: _________________

Please list other physicians you currently see and their specialties:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
___________________________________________

Past Medical History:

Diagnosed: Year

___Insomnia ____________

___Heart Murmur ____________

___Stroke or TIA ____________

___Alzheimer's ____________

___Shortness of Breath ____________

___High Blood Pressure ____________

___High Cholesterol ____________

___Hardening of arteries ____________

___Nasal Polyps ____________

___Emphysema ____________

___COPD ____________

___Asthma ____________

___Chronic bronchitis ____________

___Pneumonia ____________

___Sleep Apnea ____________

___Hypoglycemia ____________

___Diabetes ____________

___Irritable Bowel ____________

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___Crohn's disease ____________
___Fibromyalgia ____________
___Migraine Headaches ____________
___Hepatitis A, B or C ____________
___Cluster Headaches ____________
___Tension Headaches ____________
___Chronic Fatigue ____________
___Sarcoidosis ____________
___Panic attacks ____________
___Multiple Sclerosis ____________
___Depression ____________
___Heart Attack ____________

___Neurological disease ____________
___Angina ____________
___Tuberculosis ____________
___Prostate Cancer ____________
___Pulmonary embolism ____________
___Deep Vein Thrombosis ____________
___Melanoma ____________
___Colon Cancer ____________
___Breast Cancer ____________
___Ovarian Cancer ____________
___Hyperthyroidism ____________
___Reflux or GERD ____________
___Allergic Rhinitis ____________
___Bulimia or Anorexia ____________

Surgeries

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Hospitalizations: (most recent)

Date: ________________________________ Where: ________________________________

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**Reason:**
______________________________________________________________________

**Injuries/Fractures**: (type, dates and how injured)

______________________________________________________________________
_____________

______________________________________________________________________
_____________

**Family History:**

Mother: Age (if living) _______ If deceased, age at death ________ Cause of death: ________________

Medical history:
______________________________________________________________________

Father: Age (if living)_______ If deceased, age at death___________ Cause of death:______________

Medical history:______________________________________________________________

Brother(s) Living_____________ Deceased:_________________

Medical history:______________________________________________________________

Sister(s) Living______________ Deceased:_________________

Medical history:______________________________________________________________

**Allergies:** (medications, food, other substances, please list all)

Allergies: Y N

1. ___________________________________ Severity: Low 2 3 4 Mild 6 7 8 9 High
2. ___________________________________ Severity: Low 2 3 4 Mild 6 7 8 9 High
3. ___________________________________ Severity: Low 2 3 4 Mild 6 7 8 9 High
4. ___________________________________ Severity: Low 2 3 4 Mild 6 7 8 9 High

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**Present Medications: (Prescription, over the counter and herbs/supplements)**

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

Name________________________ Dose _______________ # Taken daily __________ Reason ______________

**Chief Complaint:**
Please list below the main reason for your visit today.

______________________________________________________________________________

Currently or in the recent past, have you had any of the following symptoms: (check all that apply)

□ Recurrent headaches
□ Chest tightness
□ Coughing up blood
□ Swollen glands
□ Muscle weakness/ pain
□ Joint pain
□ Chills
□ Irregular heartbeat
□ Head injury

□ General weakness
□ Swollen ankles/feet
□ Numbness
□ Heart flutter
□ Shortness of breath
□ Chronic cough
□ Nervousness, panic
□ Severe snoring
□ Chest pain

□ Being too hot or cold
□ Trouble swallowing
□ Seizures/convulsions
□ Unexplained fever
□ Loss of consciousness
□ Depression
□ Feeling faint
□ Mood swings
□ Unusual weight loss

□ Pain in legs
□ Tingling hands/feet
□ Memory loss
□ Generalized fatigue
□ Daytime sleepiness
□ Trouble sleeping
□ Dizziness or off-balance
□ Constant sinus drainage

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Patient Registration Form – Disclosures and Consents

Patient Name:________________________________ Date of Birth:______________________

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to Eduardo E. Chang M.D. P.A or Houston Intensive Care and Pulmonary Associates for services rendered to my dependents or me by the physician or someone under his supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due to Eduardo E. Chang M.D. P.A or Houston Intensive Care and Pulmonary Associates that they are unable to collect from my insurance carrier(s) for whatever reason. I also understand that I am responsible for verifying and obtaining any referrals required by my insurance plan. Initials:__________

Medicare/Medicaid:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that those programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Eduardo E. Chang M.D. P.A or Houston Intensive Care and Pulmonary Associates on my behalf. Initials:_____

Check-In/Late Arrivals/No Show/Late Cancellations:
I certify I have read and understand the "No Show/Cancellation Policy" on page one (1) of this packet. We require a 24-hour advance notice if you must cancel your appointment. If you arrive more than 15 minutes past your scheduled appointment time, you will be asked to reschedule or wait until there is a break in the practitioner's schedule where you can be worked in so that other patients are not inconvenienced. Please arrive at least 15 minutes prior to your appointment time so that all paperwork may be completed before you are scheduled to see the practitioner. Current insurance card and ID will be required to be presente3d at each visit. I certify I understand that payments of co-pays, deductibles, past balances or fees for non-covered services will be required at the time of service. Initials:__________

Authorization to Mail, Call or E-Mail:
I certify that I understand the privacy risk of the mail, phone calls and e-mails. I hereby authorize Eduardo E. Chang M.D. P.A or Houston Intensive Care and Pulmonary Associates or their representatives to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying your office in writing. Initials:__________

HIPPA/Confidentiality and Non-Disclosure Agreement:

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I understand that as part of my healthcare, these organizations originate and maintain health records describing my health history, symptoms, examinations and test results, diagnoses, treatments and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a sources of information for applying my diagnosis and surgical information to my bill, a means by which third-party payers can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. Initials:___________

I wish to be contacted in the following manner: (check all that apply)

- ☐ Cell phone: ___________________________
- ☐ Home Phone: _________________________
- ☐ Email: _______________________________

I give permission to Eduardo E. Chang M.D. P.A or Houston Intensive Care and Pulmonary Associates, associates, medical assistants and/or staff to disclose/discuss my medical information with the following individuals:

Name___________________________ Relationship______________________
Phone____________________

Name___________________________ Relationship______________________
Phone____________________

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agreed to the terms and conditions above as set out by Eduardo E. Chang M.D. P.A or Houston Intensive Care and Pulmonary Associates. I agree to follow and adhere to all policies. I understand my rights and responsibilities as stated in this patient registration/disclosure and consent form. I have been given a chance to ask questions and answers have been provided to my satisfaction.

Patient Signature________________________________________________
Date_________________________